

**Senate File 357 - Introduced**

SENATE FILE 357  
BY COMMITTEE ON HUMAN  
RESOURCES

(SUCCESSOR TO SSB 1127)

**A BILL FOR**

1 An Act relating to Medicaid program integrity, and providing  
2 penalties.  
3 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

1 Section 1. Section 10A.108, subsections 6 and 7, Code 2013,  
2 are amended to read as follows:

3 6. The department shall pay, from moneys appropriated to  
4 the department for this purpose, recording fees as provided  
5 in section 331.604, for the recording of the lien, ~~or for~~  
6 ~~satisfaction of the lien.~~

7 7. Upon payment of a debt for which the director has filed  
8 notice with a county recorder, the director shall ~~file a~~  
9 provide to the debtor a satisfaction of the debt. The debtor  
10 shall be responsible for filing the satisfaction of the debt  
11 with the recorder and the recorder shall enter the satisfaction  
12 on the notice on file in the recorder's office.

13 Sec. 2. Section 249A.2, Code 2013, is amended by adding the  
14 following new subsection:

15 NEW SUBSECTION. 8A. "*Overpayment*" means any funds that  
16 a provider receives or retains under the medical assistance  
17 program to which the person, after applicable reconciliation,  
18 is not entitled. To the extent the provider and the department  
19 disagree as to whether the provider is entitled to funds  
20 received or retained under the medical assistance program,  
21 "*overpayment*" includes such funds for which the provider's  
22 administrative and judicial review remedies under 441 IAC  
23 ch. 7 and chapter 17A have been exhausted. For purposes of  
24 repayment, an overpayment may include interest in accordance  
25 with section 249A.41.

26 Sec. 3. NEW SECTION. 249A.39 Reporting of overpayment.

27 1. A provider who has received an overpayment shall notify  
28 in writing, and return the overpayment to, the department,  
29 the department's agent, or the department's contractor, as  
30 appropriate. The notification shall include the reason for the  
31 return of the overpayment.

32 2. Notification and return of an overpayment under this  
33 section shall be provided by no later than the later of either  
34 of the following, as applicable:

35 a. The date which is sixty days after the date on which the

1 overpayment was identified by the provider.

2     *b.* The date any corresponding cost report is due.

3     3. A violation of this section is a violation of chapter  
4 685.

5     Sec. 4. NEW SECTION.   **249A.40 Involuntarily dissolved**  
6 **providers — overpayments or incorrect payments.**

7     Medical assistance paid to a provider following involuntary  
8 administrative dissolution of the provider pursuant to chapter  
9 490, division XIV, part B, shall be considered incorrectly  
10 paid for the purposes of section 249A.5 and the provider  
11 shall be considered to have received an overpayment for the  
12 purposes of this subchapter. For the purposes of this section,  
13 the overpayment shall not accrue until after a grace period  
14 of ninety days following receipt of notice by the provider  
15 of the dissolution from the department. Notwithstanding  
16 section 490.1422, or any other similar retroactive provision  
17 for reinstatement, the director shall recoup any medical  
18 assistance paid to a provider while the provider was dissolved  
19 if the provider is not retroactively reinstated within the  
20 ninety-day grace period. The principals of the provider shall  
21 be personally liable for the incorrect payment or overpayment.

22     Sec. 5. NEW SECTION.   **249A.41 Overpayment — interest.**

23     1. Interest may be collected upon any overpayment  
24 determined to have been made and shall accrue at the rate and  
25 in the manner specified in this section.

26     2. Prior to the provision of a notice of overpayment to  
27 the provider, interest shall accrue at the statutory rate for  
28 prejudgment interest applicable in civil actions.

29     3. After the provision of a notice of overpayment to the  
30 provider and after all of the provider's administrative and  
31 judicial review remedies under 441 IAC ch. 7 and chapter 17A  
32 have been exhausted, interest shall accrue at the statutory  
33 rate for prejudgment interest applicable in civil actions plus  
34 five percent per annum, or the maximum legal rate, whichever is  
35 lower.

1     4. At the discretion of the director, interest on an  
2 overpayment may be waived in whole or in part when the  
3 department determines the imposition of interest would produce  
4 an unjust result, would unduly burden the provider, or would  
5 substantially delay the prompt and efficient resolution of an  
6 outstanding audit or investigation.

7     Sec. 6. NEW SECTION.   **249A.42 Overpayment — limitations**  
8 **periods.**

9     1. An administrative action to recover an overpayment to a  
10 provider shall be commenced within five years of the date the  
11 overpayment was incurred. For the purposes of this subsection,  
12 "*incurred*" means the date the medical assistance claim was  
13 paid, or the date any applicable reconciliation was completed,  
14 whichever is later.

15     2. An administrative action to impose a sanction related  
16 to an overpayment to a provider shall be commenced within  
17 five years of the date the conduct underlying the sanction  
18 concluded, or the director discovered such conduct, whichever  
19 is later.

20     Sec. 7. NEW SECTION.   **249A.43 Provider overpayment — notice**  
21 **— judgment.**

22     1. Any overpayment to a provider under this chapter shall  
23 become a judgment against the provider, by operation of law,  
24 ninety days after a notice of overpayment is personally served  
25 upon the enrolled provider as required in the Iowa rules of  
26 civil procedure or by certified mail, return receipt requested,  
27 by the director or the attorney general or, if applicable,  
28 upon exhaustion of the provider's administrative and judicial  
29 review remedies under 441 IAC ch. 7 or chapter 17A, whichever  
30 is later. The judgment is entitled to full faith and credit in  
31 all states.

32     2. The notice of overpayment shall include the amount and  
33 cause of the overpayment, the provider's appeal rights, and a  
34 disclaimer that a judgment may be established if an appeal is  
35 not timely filed or if an appeal is filed and at the conclusion

1 of the administrative process under chapter 17A a determination  
2 is made that there is an overpayment.

3 3. An affidavit of service of a notice of entry of judgment  
4 shall be made by first class mail at the address where the  
5 debtor was served with the notice of overpayment. Service is  
6 completed upon mailing as specified in this paragraph.

7 4. On or after the date an unpaid overpayment becomes a  
8 judgment by operation of law, the director or the attorney  
9 general may file all of the following with the district court:

10 a. A statement identifying, or a copy of, the notice of  
11 overpayment.

12 b. Proof of service of the notice of overpayment.

13 c. An affidavit of default, stating the full name,  
14 occupation, place of residence, and last known post office  
15 address of the debtor; the name and post office address of the  
16 department; the date or dates the overpayment was incurred;  
17 the program under which the debtor was overpaid; and the total  
18 amount of the judgment.

19 5. Nothing in this section shall be construed to impede or  
20 restrict alternative methods of recovery of the overpayments  
21 specified in this section or of overpayments which do not meet  
22 the requirements of this section.

23 Sec. 8. NEW SECTION. 249A.44 Overpayment — emergency  
24 relief.

25 1. Concurrently with a withholding of payment, the  
26 imposition of a sanction, or the institution of a criminal,  
27 civil, or administrative proceeding against a provider or  
28 other person for overpayment, the director or the attorney  
29 general may bring an action for a temporary restraining order  
30 or injunctive relief to prevent a provider or other person  
31 from whom recovery may be sought, from transferring property  
32 or otherwise taking action to protect the provider's or other  
33 person's business inconsistent with the recovery sought.

34 2. To obtain such relief, the director or the attorney  
35 general shall demonstrate all necessary requirements for the

1 relief to be granted.

2 3. If an injunction is granted, the court may appoint a  
3 receiver to protect the property and business of the provider  
4 or other person from whom recovery may be sought. The court  
5 shall assess the costs of the receiver to the provider or other  
6 person.

7 4. The director or the attorney general may file a lis  
8 pendens on the property of the provider or other person  
9 during the pendency of a criminal, civil, or administrative  
10 proceeding.

11 5. When requested by the court, the director, or the  
12 attorney general, a provider or other person from whom recovery  
13 may be sought shall have an affirmative duty to fully disclose  
14 all property and liabilities to the requester.

15 6. An action brought under this section may be brought in  
16 the district court for Polk county or any other county in which  
17 a provider or other person from whom recovery may be sought has  
18 its principal place of business or is domiciled.

19 Sec. 9. NEW SECTION. 249A.45 **Provider's third-party**  
20 **submissions.**

21 1. The department may refuse to accept a financial and  
22 statistical report, cost report, or any other submission  
23 from any third party acting under a provider's authority or  
24 direction to prepare or submit such documents or information,  
25 for good cause shown. For the purposes of this section,  
26 "*good cause*", includes but is not limited to a pattern or  
27 practice of submitting unallowable costs on cost reports;  
28 making a false statement or certification to the director or  
29 any representative of the department; professional negligence  
30 or other demonstrated lack of knowledge of the cost reporting  
31 process; conviction under a federal or state law relating to  
32 the operation of a publicly funded program; or submission of a  
33 false claim under chapter 685.

34 2. If the department refuses to accept a cost report  
35 from a third party for good cause under this section, the

1 third party shall be strictly liable to the provider for all  
2 fees incurred in preparation of the cost report, as well as  
3 reasonable attorney fees and costs. The department shall not  
4 take any adverse action against a provider that results from  
5 the unintentional delay in the submission of a new cost report  
6 or other submission necessitated by the department's refusal to  
7 accept a cost report or other submission under this section.  
8 The department shall notify an affected provider within seven  
9 business days of any refusal to accept a cost report.

10     Sec. 10. NEW SECTION.   **249A.46 Liability of other persons**  
11 **— repayment of claims.**

12     1. The department may require repayment of medical  
13 assistance paid from the person submitting an incorrect or  
14 improper claim, the person causing the claim to be submitted,  
15 or the person receiving payment for the claim.

16     2. Nothing in this section shall be construed to impede or  
17 restrict alternative recovery methods for claims specified in  
18 this section or claims which do not meet the requirements of  
19 this section.

20     Sec. 11. NEW SECTION.   **249A.47 Improperly filed claims**  
21 **— other violations — imposition of monetary recovery and**  
22 **sanctions.**

23     1. In addition to any other remedies or penalties prescribed  
24 by law, including but not limited to those specified pursuant  
25 to section 249A.8 or chapter 685, all of the following shall be  
26 applicable to violations under the medical assistance program:

27     a. A person who intentionally and purposefully presents  
28 or causes to be presented to the department a claim that the  
29 department determines meets any of the following criteria  
30 is subject to a civil penalty of not more than ten thousand  
31 dollars for each item or service:

32     (1) A claim for medical or other items or services that  
33 the provider knows was not provided as claimed, including a  
34 claim by any provider who engages in a pattern or practice  
35 of presenting or causing to be presented a claim for an item

1 or service that is based on a billing code that the provider  
2 knows will result in a greater payment to the provider than the  
3 billing code the provider knows is applicable to the item or  
4 service actually provided.

5 (2) A claim for medical or other items or services the  
6 provider knows to be false or fraudulent.

7 (3) A claim for a physician service or an item or service  
8 incident to a physician service by a person who knows that the  
9 individual who furnished or supervised the furnishing of the  
10 service meets any of the following:

11 (a) Was not licensed as a physician.

12 (b) Was licensed as a physician, but such license had been  
13 obtained through a misrepresentation of material fact.

14 (c) Represented to the patient at the time the service  
15 was furnished that the physician was certified in a medical  
16 specialty by a medical specialty board when the individual was  
17 not so certified.

18 (4) A claim for medical or other items or services furnished  
19 during a period in which the provider was excluded from  
20 providing such items or services.

21 (5) A claim for a pattern of medical or other items or  
22 services that a provider knows were not medically necessary.

23 b. A provider who intentionally and purposefully presents  
24 or causes to be presented to any person a request for payment  
25 which is in violation of the terms of either of the following  
26 is subject to a civil penalty of not more than ten thousand  
27 dollars for each item or service:

28 (1) An agreement with the department or a requirement of a  
29 state plan under Tit. XIX or XXI of the federal Social Security  
30 Act not to charge a person for an item or service in excess of  
31 the amount permitted to be charged.

32 (2) An agreement to be a participating provider.

33 c. A provider who is not an organization, agency, or  
34 other entity, and knowing that the provider is excluded from  
35 participating in a program under Tit. XVIII, XIX, or XXI of the



1 federal Social Security Act at the time of the exclusion, who  
2 does any of the following, is subject to a civil penalty of ten  
3 thousand dollars for each day that the prohibited relationship  
4 occurs:

5 (1) Retains a direct or indirect ownership or control  
6 interest in an entity that is participating in such programs,  
7 and knows of the action constituting the basis for the  
8 exclusion.

9 (2) Is an officer or managing employee of such an entity.

10 d. A provider who intentionally and purposefully offers  
11 to or transfers remuneration to any individual eligible for  
12 benefits under Tit. XIX or XXI of the federal Social Security  
13 Act and who knows such offer or remuneration is likely to  
14 influence such individual to order or receive from a particular  
15 provider any item or service for which payment may be made, in  
16 whole or in part, under Tit. XIX or XXI of the federal Social  
17 Security Act, is subject to a civil penalty of not more than  
18 ten thousand dollars for each item or service.

19 e. A provider who intentionally and purposefully arranges or  
20 contracts, by employment or otherwise, with an individual or  
21 entity that the provider knows is excluded from participation  
22 under Tit. XVIII, XIX, or XXI of the federal Social Security  
23 Act, for the provision of items or services for which payment  
24 may be made under such titles, is subject to a civil penalty of  
25 not more than ten thousand dollars for each item or service.

26 f. A provider who intentionally and purposefully offers,  
27 pays, solicits, or receives payment, directly or indirectly, to  
28 reduce or limit services provided to any individual eligible  
29 for benefits under Tit. XVIII, XIX, or XXI of the federal  
30 Social Security Act, is subject to a civil penalty of not more  
31 than fifty thousand dollars for each act.

32 g. A provider who intentionally and purposefully makes,  
33 uses, or causes to be made or used, a false record or statement  
34 material to a false or fraudulent claim for payment for items  
35 and services furnished under Tit. XIX or XXI of the federal

1 Social Security Act, is subject to a civil penalty of not more  
2 than fifty thousand dollars for each false record or statement.

3 *h.* A provider who intentionally and purposefully fails  
4 to grant timely access, upon reasonable request and without  
5 good cause, to the department for the purpose of audits,  
6 investigations, evaluations, or other functions of the  
7 department, is subject to a civil penalty of fifteen thousand  
8 dollars for each day of the failure.

9 *i.* A provider who intentionally and purposefully makes  
10 or causes to be made any false statement, omission, or  
11 misrepresentation of a material fact in any application, bid,  
12 or contract to participate or enroll as a provider of services  
13 or a supplier under Tit. XVIII, XIX, or XXI of the federal  
14 Social Security Act, including a managed care organization or  
15 entity that applies to participate as a provider of services  
16 or supplier in such a managed care organization or plan, is  
17 subject to a civil penalty of fifty thousand dollars for each  
18 false statement, omission, or misrepresentation of a material  
19 fact.

20 *j.* A provider who intentionally and purposefully fails to  
21 report and return an overpayment in accordance with section  
22 249A.41 is subject to a civil penalty of ten thousand dollars  
23 for each failure to report and return an overpayment.

24 2. In addition to the civil penalties prescribed under  
25 subsection 1, for any violation specified in subsection 1, a  
26 provider shall be subject to the following, as applicable:

27 *a.* For violations specified in subsection 1, paragraph  
28 "a", "b", "c", "d", "e", "g", "h", or "j", an assessment of not  
29 more than three times the amount claimed for each such item or  
30 service in lieu of damages sustained by the department because  
31 of such claim.

32 *b.* For a violation specified in subsection 1, paragraph  
33 "f", damages of not more than three times the total amount of  
34 remuneration offered, paid, solicited, or received, without  
35 regard to whether a portion of such remuneration was offered,

1 paid, solicited, or received for a lawful purpose.

2     *c.* For a violation specified in subsection 1, paragraph "i",  
3 an assessment of not more than three times the total amount  
4 claimed for each item or service for which payment was made  
5 based upon the application containing the false statement,  
6 omission, or misrepresentation of a material fact.

7     3. In determining the amount or scope of any penalty  
8 or assessment imposed pursuant to a violation specified in  
9 subsection 1, the director shall consider all of the following:

10     *a.* The nature of the claims and the circumstances under  
11 which they were presented.

12     *b.* The degree of culpability, history of prior offenses, and  
13 financial condition of the person against whom the penalties or  
14 assessments are levied.

15     *c.* Such other matters as justice may require.

16     4. Of any amount recovered arising out of a claim under Tit.  
17 XIX or XXI of the federal Social Security Act, the department  
18 shall receive the amount bearing the same proportion paid by  
19 the department for such claims, including any federal share  
20 that must be returned to the centers for Medicare and Medicaid  
21 services of the United States department of human services.  
22 The remainder of any amount recovered shall be deposited in the  
23 general fund of the state.

24     5. Civil penalties levied under this section are appealable  
25 under 441 IAC ch. 7, but, notwithstanding any provision to the  
26 contrary in that chapter, the appellant shall bear the burden  
27 to prove by clear and convincing evidence that the claim was  
28 not filed improperly.

29     6. For the purposes of this section, "claim" includes but is  
30 not limited to the submission of a cost report.

31     Sec. 12. NEW SECTION.   **249A.48 Temporary moratoria.**

32     1. The Iowa Medicaid enterprise shall impose a temporary  
33 moratorium on the enrollment of new providers or provider types  
34 identified by the centers for Medicare and Medicaid services of  
35 the United States department of health and human services as

1 posing an increased risk to the medical assistance program.

2     *a.* This section shall not be interpreted to require the  
3 Iowa Medicaid enterprise to impose a moratorium if the Iowa  
4 Medicaid enterprise determines that imposition of a temporary  
5 moratorium would adversely affect access of recipients to  
6 medical assistance services.

7     *b.* If the Iowa Medicaid enterprise makes a determination  
8 as specified in paragraph "a", the Iowa Medicaid enterprise  
9 shall notify the centers for Medicare and Medicaid services of  
10 the United States department of health and human services in  
11 writing.

12     2. The Iowa Medicaid enterprise may impose a temporary  
13 moratorium on the enrollment of new providers, or impose  
14 numerical caps or other limits that the Iowa Medicaid  
15 enterprise and the centers for Medicare and Medicaid services  
16 identify as having a significant potential for fraud, waste, or  
17 abuse.

18     *a.* Before implementing the moratorium, caps, or other  
19 limits, the Iowa Medicaid enterprise shall determine that its  
20 action would not adversely impact access by recipients to  
21 medical assistance services.

22     *b.* The Iowa Medicaid enterprise shall notify, in writing,  
23 the centers for Medicare and Medicaid services, if the Iowa  
24 Medicaid enterprise seeks to impose a moratorium under this  
25 subsection, including all of the details of the moratorium.  
26 The Iowa Medicaid enterprise shall receive approval from the  
27 centers for Medicare and Medicaid services prior to imposing a  
28 moratorium under this subsection.

29     3. *a.* The Iowa Medicaid enterprise shall impose any  
30 moratorium for an initial period of six months.

31     *b.* If the Iowa Medicaid enterprise determines that it  
32 is necessary, the Iowa Medicaid enterprise may extend the  
33 moratorium in six-month increments. Each time a moratorium  
34 is extended, the Iowa Medicaid enterprise shall document, in  
35 writing, the necessity for extending the moratorium.

1     Sec. 13. NEW SECTION.   **249A.49 Internet site — providers**  
2 **found in violation of medical assistance program.**

3     1. The director shall maintain on the department's internet  
4 site, in a manner readily accessible by the public, all of the  
5 following:

6     a. A list of all providers that the department has  
7 terminated, suspended, or placed on probation.

8     b. A list of all providers that have failed to return an  
9 identified overpayment of medical assistance within the time  
10 frame specified in section 249A.41.

11    c. A list of all providers found liable for a false claims  
12 law violation related to the medical assistance program under  
13 chapter 685.

14    2. The director shall take all appropriate measures to  
15 safeguard the protected health information, social security  
16 numbers, and other information of the individuals involved,  
17 which may be redacted or omitted as provided in rule of civil  
18 procedure 1.422. A provider shall not be included on the  
19 internet site until all administrative and judicial remedies  
20 relating to the violation have been exhausted.

21    Sec. 14. CODE EDITOR DIRECTIVES. The Code editor shall do  
22 all of the following:

23    1. Create a new subchapter in chapter 249A, entitled  
24 "Medical Assistance Eligibility and Miscellaneous Provisions",  
25 which shall include sections 249A.1 through 249A.4, section  
26 249A.4B, sections 249A.9 through 249A.13, sections 249A.15  
27 through 249A.18A, and sections 249A.20 through 249A.38,  
28 Code 2013. The Code editor may renumber sections within the  
29 subchapter and shall correct internal references as necessary.

30    2. Create a new subchapter in chapter 249A, entitled  
31 "Medical Assistance Program Integrity", which shall include  
32 sections 249A.39 through 249A.49, as enacted in this Act.

33    3. a. Transfer section 249A.4A, sections 249A.5 through  
34 249A.8, section 249A.14, and section 249A.19, Code 2013, to the  
35 new subchapter entitled "Medical Assistance Program Integrity".

1 The Code editor shall renumber the transferred sections as  
2 follows:

- 3 (1) Section 249A.4A as section 249A.52.
- 4 (2) Section 249A.5 as section 249A.53.
- 5 (3) Section 249A.6 as section 249A.54.
- 6 (4) Section 249A.6A as section 249A.55.
- 7 (5) Section 249A.7 as section 249A.50.
- 8 (6) Section 249A.8 as section 249A.51.
- 9 (7) Section 249A.14 as section 249A.56.
- 10 (8) Section 249A.19 as section 249A.57.

11 b. The Code editor shall correct internal references as  
12 necessary.

13 EXPLANATION

14 This bill relates to medical assistance (Medicaid) program  
15 integrity.

16 The bill amends Code section 10A.108, which provides that  
17 if a person refuses or neglects to repay benefits or provider  
18 payments inappropriately obtained from the department of human  
19 services (DHS), the amount inappropriately obtained constitutes  
20 a debt and is a lien in favor of the state upon all property  
21 belonging to the person. The bill provides that DHS is no  
22 longer responsible for paying the fee for recording of the  
23 satisfaction of the lien or the debt, but that this is the  
24 responsibility of the debtor.

25 The bill requires a provider who has received an overpayment  
26 to provide notification in writing and return the overpayment  
27 to the department, department's agent, or the department's  
28 contractor, as applicable. The notification and return of the  
29 overpayment are to be completed the later of 60 days after the  
30 date on which the overpayment was identified by the provider or  
31 the date any corresponding cost report is due, as applicable.  
32 Violation of this provision constitutes a violation of the  
33 false claims Act (Code chapter 685).

34 The bill provides that if a provider is administratively and  
35 involuntarily dissolved and receives payments following the

1 dissolution, the payments are considered to be overpayments and  
2 to be incorrectly paid.

3 The bill provides for the accrual of interest on, and the  
4 rate of interest applicable to, overpayments.

5 The bill requires that an administrative action to recover  
6 an overpayment be commenced within five years of the date the  
7 overpayment occurred. An administrative action to impose  
8 a sanction on a provider related to an overpayment must be  
9 commenced within five years of the date the conduct underlying  
10 the sanction concluded, or the director of human services  
11 discovered such conduct, whichever is first.

12 The bill provides a process to establish a judgment by  
13 operation of law for any overpayment to a Medicaid provider  
14 90 days after the notice of overpayment is served upon the  
15 provider or after all administrative and judicial review  
16 remedies are exhausted.

17 The bill provides for emergency relief relating to  
18 overpayments to Medicaid providers or others. The bill  
19 provides that the director of human services or the attorney  
20 general may bring an action for a temporary restraining order  
21 or injunctive relief to prevent a provider or other person from  
22 transferring property or otherwise taking actions to protect  
23 the provider's or other person's business inconsistent with the  
24 recovery being sought.

25 The bill authorizes DHS to refuse to accept financial and  
26 statistical reports, cost reports, and other submissions from  
27 third parties acting under the authority or direction of a  
28 provider for good cause, and defines "good cause". If DHS  
29 refuses to accept a submission from such a third party, the  
30 third party is strictly liable to the provider for all fees  
31 incurred, attorney fees, and other costs. The bill provides  
32 that DHS shall not take any adverse action against the provider  
33 under circumstance that result from any unintentional delay on  
34 the part of the provider in submitting a new submission.

35 The bill provides for repayment by persons other than the

1 provider for improper payments including the person submitting  
2 an incorrect or improper claim, the person causing the claim to  
3 be submitted, or the person receiving payment for the claim.

4 The bill provides specific civil penalties and assessments  
5 or damages for improperly filed claims and other violations  
6 relating to improper reimbursement under the Medicaid program.

7 The bill directs the Iowa Medicaid enterprise (IME) to  
8 impose temporary moratoria on enrollment of new providers or  
9 provider types identified by the centers for Medicare and  
10 Medicaid services of the United States department of health  
11 and human services (CMS) as posing an increased risk to the  
12 Medicaid program. The moratoria are not required if the IME  
13 determines that imposition of a temporary moratorium would  
14 adversely affect access of recipients to Medicaid services.  
15 However, if the IME makes such a determination, IME is to  
16 notify CMS in writing. The bill also authorizes IME to  
17 impose temporary moratoria on enrollment of new providers, or  
18 impose numerical caps or other limits that the IME and CMS  
19 identify as having a significant potential for fraud, waste,  
20 or abuse. Before implementing the moratoria, caps, or other  
21 limits, IME must determine that its action would not adversely  
22 impact access by recipients to Medicaid services, notify CMS  
23 in writing, and receive approval from CMS. Any moratorium is  
24 to be imposed for an initial period of six months and may then  
25 be extended in six-month increments. The necessity for any  
26 extension is to be documented in writing.

27 The bill requires the director of human services to maintain  
28 on the department's internet site, in a manner readily  
29 accessible by the public, lists of all providers that the  
30 department has terminated, suspended, or placed on probation;  
31 all providers that have failed to return an identified  
32 overpayment; and all providers found liable for a false claims  
33 law violation related to Medicaid.

34 The bill provides for all Medicaid program integrity  
35 provisions to be codified in a new subchapter under Code



1 chapter 249A (medical assistance), including the new provisions  
2 enacted in the bill and existing provisions under Code sections  
3 249A.4A (garnishment), 249A.5 (recovery of payment), 249A.6  
4 (assignment — lien), 249A.6A (restitution), 249A.7 (fraudulent  
5 practices — investigations and audits — Medicaid fraud fund),  
6 249A.8 (fraudulent practice), 249A.14 (county attorney to  
7 enforce), and 249A.19 (health care facilities — penalty).